| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CO | | (X3) DATE SURVEY | |
|--|--|--|---|---|--|
| OF CORRECTION | | A. BUILDING | COMPLETED 03/26/2012 | | |
| | 199476 | B. WING | | 03/26/2012 | |
| PROVIDER OR SUPPLIE | R | | | | |
| S OF JASPER THE | | 2909 HOWARD DR JASPER, IN 47546 | | | |
| SUMMARY S | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| (EACH DEFICIEN | NCY MUST BE PERCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE | COMPLETION | |
| REGULATORY OF | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE | |
| | | | | | |
| This visit was for State Licensure Survey dates: M 22, 23, and 26, Facility number: Provider number AIM number: 10 Survey team: To Census bed type SNF/NF: 69 Total: 69 Census Payor ty Medicare: 9 Medicaid: 47 Other:13 Total: 69 These deficiency cited in accordance of the content of | or the Recertification and Survey. March 12, 13, 14, 15, 16, 2012 1000314 11: 155478 100274210 erri Walters RN TC Carole McDaniel RN Martha Saull RN Dorothy Watts RN 1: 155478 100274210 erri Walters RN TC carole McDaniel RN martha Saull RN completed 3/29/12 | F0000 | The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation regulation. This provider respectfully requests that the 2567L Plan Correction be considered the Letter of Credible Allegation a requests a Post Certification Review on or after | ot s : n of | |
| | PROVIDER OR SUPPLIES SOF JASPER THE SUMMARY S (EACH DEFICIENT REGULATORY OF This visit was for State Licensure Survey dates: M. 22, 23, and 26, Facility number: Provider number AIM number: 10 Survey team: To Survey team: T | DENTIFICATION NUMBER: 155478 PROVIDER OR SUPPLIER S OF JASPER THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for the Recertification and State Licensure Survey. Survey dates: March 12, 13, 14, 15, 16, 22, 23, and 26, 2012 Facility number: 000314 Provider number: 155478 AIM number: 100274210 Survey team: Terri Walters RN TC Carole McDaniel RN Martha Saull RN Dorothy Watts RN Census bed type: SNF/NF: 69 Total: 69 Census Payor type: Medicare: 9 Medicaid: 47 Other:13 | OF CORRECTION IDENTIFICATION NUMBER: 155478 IDENTIFICATION NUMBER: 155478 SOF JASPER THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for the Recertification and State Licensure Survey. Survey dates: March 12, 13, 14, 15, 16, 22, 23, and 26, 2012 Facility number: 000314 Provider number: 155478 AIM number: 100274210 Survey team: Terri Walters RN TC Carole McDaniel RN Martha Saull RN Dorothy Watts RN Census bed type: SNF/NF: 69 Total: 69 Census Payor type: Medicare: 9 Medicare: 9 Medicare: 9 Medicare: 9 Medicare: 13 Total: 69 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 3/29/12 | DENTIFICATION NUMBER: 155478 REQUIDER OR SUPPLIER SOF JASPER THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for the Recertification and State Licensure Survey. Survey dates: March 12, 13, 14, 15, 16, 22, 23, and 26, 2012 Facility number: 000314 Provider number: 155478 AIM number: 100274210 Survey team: Terri Walters RN TC Carole McDaniel RN Martha Saull RN Dorothy Watts RN Census bed type: SNF/NF: 69 Total: 69 Census Payor type: Medicaid: 47 Other: 13 Total: 69 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 3/29/12 | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2012 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | IDENTIFICATION NUMBER: 155478 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | COMPI | | |
|--------------------------|----------------------|---|---|--|-------------|----------------------------|--|
| | PROVIDER OR SUPPLIES | | STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETION DATE | |
| | | | | | | | |
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FCBV11

Facility ID: 000314

If continuation sheet

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| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|---------------|--|--|----------------------------|--------|---|----------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 | | | COMPLETED | |
| | | 155478 | B. WIN | | | 03/26/ | 2012 |
| | | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | PROVIDER OR SUPPLIER | <u>.</u> | | 2909 H | OWARD DR | | |
| | S OF JASPER THE | | | JASPE | R, IN 47546 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION |
| | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCE | | DATE |
| F0176 SS=D | 483.10(n) RESIDENT SELI DEEMED SAFE An individual res drugs if the intere by §483.20(d)(2) practice is safe. Based on obse and interview thensure resident administer med residents who vereceiving medic Findings includ On 3/13/12 at 4 observed admin medication to F prepared medic Tylenol, Carved pressure contro Diabetic blood (stool softener) She left the me resident at the without ensurin taken. On 3/14/12 at 1 record was revi | cation. Resident # 2 | F01 | 76 | It is the facility's intent to ensure residents are safe to self administer medication. What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice. 1. Resident # 2 was assessed which determined to have the ability to self administer medication. 2.R.N. # 2 was counseled. 3.R.N. # 2 was placed into orientation for re-training and completion of validation skills check off list completed. How will you identify other residents having the potential be affected by the same deficient practice and what corrective action will be taken. | pe nts y ed | 04/10/2012 |
| | met appropriat | e criteria for self ninistration. There was | | | No other residents self administer medication. License Nurses were in-serviced by DNS on 4/5/12 regarding med pass | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FCBV11

Facility ID: 000314

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | | |
|--|--|---|---------|---------------------|--|--|----------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | |
| | | 155478 | B. WIN | G | | 03/26/ | 2012 |
| | PROVIDER OR SUPPLIE | | | 2909 H | ADDRESS, CITY, STATE, ZIP CODE OWARD DR R, IN 47546 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | Nursing on 3/ indicated resid screened for a | ew with the Director of 16/12 at 12:20 PM, she lents were to be ppropriateness to self dications and also have der for it. | | | administration medication police What measures will be put into place or what systemic change you will make to ensure that the deficient practice does not reconserviced by DNS on 4/5/12 regarding med pass administration which included administered medication polices. 2. Validation skill check offs from pass will be completed or each licensed nurse on all threshifts completed by DNS and/odesignee. 3.RN # 3 was placed in orientation for re-training and validation skill check off completed for med pass. How the corrective action(s) who be monitored to ensure the deficient practice will not recurrice, what quality assurance program will be put into place. | o es ee ur self y. for ee or | |
| | | | | | 1. To ensure compliance, DNS/Designee is responsible the completion of the Med Pas Procedure check off list CQI to weekly times 4 weeks, bi-mon times 2 months, and then quarterly until continued compliance is maintained for 2 | for ss ool thly | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FCBV11

Facility ID: 000314

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2012 FORM APPROVED OMB NO. 0938-0391

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | | | |
|--------------------------|----------------------------------|---|---|--|--|----------------------------|--|
| | PROVIDER OR SUPPLIE | Ē | STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY) | | (X5) COMPLETION DATE | |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION) | TAG | consecutive quarters. The of these audits will be rev by the CQI committee ove by the ED. If threshold of not achieved an action plabe developed to ensure compliance. | e results iewed erseen f 95% is | DATE | |
| | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FCBV11

Facility ID: 000314

If continuation sheet

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| STATEMEN | ENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) ! | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--------------|--|---|--|----------------------------|---|------------|------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | a. Building 00 | | | COMPLETED | | |
| | | 155478 | B. WIN | | | 03/26/2012 | | |
| | | | 1 | | ADDRESS, CITY, STATE, ZIP CODE | | | |
| NAME OF F | PROVIDER OR SUPPLIER | <u>.</u> | | 2909 H | OWARD DR | | | |
| TIMBERS | S OF JASPER THE | | | JASPEI | R, IN 47546 | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO T | | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | , The state of the | CY MUST BE PERCEDED BY FULL | | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | COMPLETION | |
| TAG F0253 | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCE | | DATE | |
| SS=D | SERVICES | G & MAINTENANCE provide housekeeping and | | | | | | |
| | maintenance ser a sanitary, order | vices necessary to maintain ly, and comfortable interior. | F02 | 5.0 | | | 0.4/1.0/2.01.2 | |
| | | ervation and interview, | F02 | 53 | The feelith decimal in the common | | 04/10/2012 | |
| | the facility failed | | | | The facility's intent is to ensure the environment is free from | 9 | | |
| | | as free of objectionable | | | objectionable odors. | | | |
| | | st 2 survey days of 7 | | | | | | |
| | survey days. | | | | | | | |
| | 3/12/12 and 3/1 | 13/12 | | | \\/\bat corrective estima(s) will b | | | |
| | Findings include: | | | | What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice | nts | | |
| | On 3/12/12 at | 9:40 A.M., the building | | | are denotern produce | | | |
| | | r initial tour. Upon | | | No residents were affecte | | | |
| | | ilding from the main | | | 2.Exhaust fan repaired 3/22/ | 12. | | |
| | 1 | the following floor plan | | | | | | |
| | | the nursing station for | | | | | | |
| | | 0 halls was to the left | | | | | | |
| | of the entry inte | ersection. The 300 | | | | | | |
| | 1 | Il was located vertical | | | How will you identify other | | | |
| | _ | or. The 400 nursing | | | residents having the potential be affected by the same defici | | | |
| | | cated to the right of the | | | practice and what corrective | ent | | |
| | | Directly to the right of | | | action will be taken | | | |
| | 1 , | was a resident TV | | | | | | |
| | | loorway to the room | | | No residents were affecte | d. | | |
| | | unit hall. Directly | | | 2.Laundry barrels will be disinfected once a week. | | | |
| | • | from the TV room, was | | | 3.Soiled briefs barrel will be | | | |
| | | r room and a women's | | | emptied once per shift and mo | re | | |
| | shower room, a | again with the doors | | | often as needed. | | | |
| | • | e 400 unit hall. At this | | | 4.Laundry barrels will be | | | |
| | ' " | ts were observed | | | emptied at least 2 times per laundry and more often as | | | |
| | | heelchairs in the TV | | | needed. | | | |
| | _ | his time, 2 residents | | | 5.Exhaust fan repaired. | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FCBV11

Facility ID: 000314

If continuation sheet Page 6 of 24

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|--|------------------------------|----------------------------|--------|--|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING COMPLETED | | | ETED | |
| | | 155478 | B. WIN | | | 03/26/2 | 2012 |
| | | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | ę. | | 2909 H | OWARD DR | | |
| TIMBER | TIMBERS OF JASPER THE | | | JASPEI | R, IN 47546 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | `` | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | - | TAG | DEFICIENCY) | | DATE |
| | were observed | • | | | | | |
| | wheelchairs at | the entry intersection. | | | | | |
| | | | | | What measures will be put into | o | |
| | On 3/12/12 at 10:05 A.M., during | | | | place or what systemic change | | |
| | | e 300 hall, a pervasive | | | you will make to ensure that the | | |
| | foul odor of human excrement and urine was noted radiating from the men's shower room. At this time, observed in the men's shower room | | | | deficient practice does not rec | ur | |
| | | | | | Laundry barrels will be | | |
| | | | | | disinfected once a week. | | |
| | | | | | 2.Soiled briefs barrel will be | | |
| | were 4 barrel type trash receptacles | | | | emptied once per shift and mo | re | |
| | filled with soiled depends and other | | | | often as needed. | | |
| | refuse. Two of the barrels were full to | | | | 3.Laundry barrels will be emptied at least 2 times per | | |
| | the point of the lids being unable to | | | | laundry and more often as | | |
| | be securely clo | sed. This pervasive | | | needed. | | |
| | foul odor remain | ined to be detected at | | | 4.Exhaust fan will be placed | | |
| | 11 A.M., 12 P.I | M., 1 P.M. and 2 P.M. | | | the preventative schedule to b checked monthly. | е | |
| | On 3/12/12 at | 12:09 D.M. o | | | 5.The License Nurse will | | |
| | | • | | | monitor shower rooms for | | |
| | | nily member was | | | cleanliness/odor each shift 7 d | lays | |
| | | his confidential family | | | a week. | | |
| | | ted they detected "a | | | | | |
| | _ | r in the 300 and 400 | | | | | |
| | | /." They also indicated | | | How the corrective action(s) w | ill | |
| | , | d why the workers at | | | be monitored to ensure the | | |
| | the facility don' | t notice the odor." | | | deficient practice will not recur i.e., what quality assurance | , | |
| | | | | | program will be put into place | | |
| | | 10 A.M., there again | | | | | |
| | - | re stale urine odor | | | The Maintenance Director | | |
| | | 0 and 400 halls at the | | | will check operation of exhaus | | |
| | | the nurses station and | | | fan monthly during preventativ maintenance check and | e | |
| | | This pervasive foul | | | documented on preventative | | |
| | | to be detected at 11 | | | sheet. | | |
| | | 1 P.M. and 2 P.M. At | | | 2.To ensure compliance, the | е | |
| | this time, 3 res | sidents were observed | | | DNS/Designee is responsible | for | |
| | in the TV room | in their wheelchairs. | | | the completion of the Nurse | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE C | ONSTRUCTION | (X3) DATE SURVEY | |
|--|---|--|--------------|---|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | | COMPLETED |
| | | 155478 | B. WING | | 03/26/2012 |
| NAME OF T | DOMDED OF GUIDNASS | | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF F | PROVIDER OR SUPPLIEF | (| 2909 H | HOWARD DR | |
| | S OF JASPER THE | | | ER, IN 47546 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID PREFIX | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | EACH DEFICIENCY MUST BE PERCEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | |
| TAG | | · · · · · · · · · · · · · · · · · · · | TAG | · · | DATE |
| | | e, 1 resident was | | Rounds CQI tool weekly times weeks, bi-monthly times 2 | 9 4 |
| | observed sitting at the nursing station intersection awaiting a ride for an | | | months, and then quarterly un | itil |
| | | | | continued compliance is | |
| | appointment. | | | maintained for 2 consecutive | |
| | | observed sitting at this | | quarters. The results of these | 001 |
| | | vaiting staff to push | | audits will be reviewed by the committee overseen by the El | |
| | them in their wheelchairs to the dining | | | threshold of 95% is not achiev | |
| | room. | | | an action plan will be develop | |
| | | | | to ensure compliance. | |
| | | 11:30 A.M. CNA | | | |
| | | ing Assistant) #10 was | | | |
| | | NA #10 indicated she | | | |
| | | n the 300 and 400 | | | |
| | _ | oday. She indicated | | | |
| | resident showe | ers are given in both the | | | |
| | units men's and | d women's shower | | | |
| | rooms. CNA# | 10 indicated usually | | | |
| | the women's sh | nower room is used as | | | |
| | the heater and | ventilation doesn't | | | |
| | work in the me | n's shower room. CNA | | | |
| | #10 indicated | soiled resident | | | |
| | clothing, towels | s and sheets were | | | |
| | stored in the ba | arrels housed in one of | | | |
| | the two shower | r stalls in the men's | | | |
| | shower room. | | | | |
| | | | | | |
| | | 3:05 P.M., the Mens | | | |
| | shower room | on the 300/400 unit | | | |
| | was toured wit | th the Maintenance | | | |
| | staff. Just ins | ide the door, were | | | |
| | two switches I | located on the wall to | | | |
| | the left. One o | of the switches | | | |
| | operated the li | ights in the room | | | |
| | l - | d. The other switch, | | | |
| | | · · · · · · · · · · · · · · · · · · · | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FCBV11

Facility ID: 000314

If continuation sheet

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| | of Correction identification number: 155478 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | COMPL 03/26/ | ETED |
|--------------------------|--|--|--|--------------|----------------------------|
| | PROVIDER OR SUPPLIER S OF JASPER THE | 2909 H | ADDRESS, CITY, STATE, ZIP OWARD DR R, IN 47546 | CODE | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| | when activated, did nothing. At this time, the Maintenance staff removed a dust coated grate from the ceiling over the shower stall. He indicated this was the exhaust fan and that is currently wasn't working. He indicated he was unsure as to how long the fan wasn't working as he wasn't aware the fan wasn't working. At this time, 4 covered barrels were observed in one of the two shower stall areas. On 3/23/12 at 3:20 P.M., the ADON (Assistant Director of Nursing) was interviewed. She indicated there were 44 residents on the 300 and 400 unit halls that would use the men's and women's shower rooms. 3.1-19(f) | | | | |

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Event ID: FCBV11

Facility ID: 000314

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155478 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING | | | (X3) DATE SURVEY COMPLETED 03/26/2012 | | |
|--|---|---|--------|---------------------|--|--|----------------------------|
| | | 155476 | B. WIN | G | | 03/26/ | 2012 |
| | ROVIDER OR SUPPLIER | | | 2909 H | ADDRESS, CITY, STATE, ZIP CODE OWARD DR R, IN 47546 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | (X5) COMPLETION DATE |
| F0323 SS=D | The facility must environment rem hazards as is poreceives adequal assistance device. Based on interverview, the facina adequate superesident from legurate unattended for incidents to the Resident #56. Findings includ. On 3/15/12 at #56's clinical regurated to the Resident with the Resident with the Resident with the propelled his wife's room et to be a looking for the propelled his wife's room et to be a looking for the propelled his wife's room et to be a looking for the propelled his wife's room et to be a looking for the propelled his wife's room et to be a looking for the propelled his several times how the court outside to court resident) sa the was outside min (minutes). Checking out the looking out | ensure that the resident ains as free of accident sible; and each resident te supervision and es to prevent accidents. View, and record lity failed to ensure rvision to prevent a eaving the facility 1 of 1 facility reported state agency. e: 11:00 A.M., Resident cord was reviewed. A sted 1/8/12 at 2:50, "Pt (patient) had just 2 per staff. He had r a door to go home. mself down toward urned left to enter has been in this area as even knocked on of secured unit) doors. ted door to left et went | F03 | 23 | The facility's intent is to ensure that the resident environment remains as free of accident hazards as is possible, and earesident receives adequate supervision and assistance devices to prevent accidents. What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice 1. Resident #56 was started 15 minute checks immediately and continues to wear wander guard. 2.Motion sensor alarm place on court yard door. How will you identify other residents having the potential be affected by the same defici practice and what corrective action will be taken 1. A complete review of residents was completed and other residents were identified | oe nts y on d to ent | 04/10/2012 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FCBV11

Facility ID: 000314

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE (| CONSTRUCTION | (X3) DATE SURVEY | |
|--|--------------------------------------|------------------------------|-------------------------|--|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A BLULDING 00 COMPLETED | | |
| | | 155478 | A. BUILDING B. WING | | 03/26/2012 |
| | | | | Γ ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | HOWARD DR | |
| TIMPED | S OF JASPER THE | | | ER, IN 47546 | |
| TIMBER | OF JASPER THE | | JAGE | ER, IN 47 540 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | ICY MUST BE PERCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| | | ng about it. Sisters | | 2.Elopement books which | |
| | visiting et updated, Dr (physician's | | | include pictures of residents a | l l |
| | name) updated | d, DON (Director of | | description will be reviewed a updated to reflect any necess | l l |
| | Nursing) updat | ed." | | changes. | sal y |
| |] | | | 3.Plan of care and C.N.A. | |
| | A nursing note | dated 1/8/12 at 5:00 | | assignment sheets have been | n |
| | P.M., indicated, "Pt has been on 15 | | | updated to reflect changes as | |
| | • | atch since above | | appropriate. | |
| | happened. No | | | 4.Placement and function o | |
| | Паррепец. Мо | problems. | | wander guard is checked each | ch |
| | 0 0/40/40 1 | 44.4= 4.44 6 100 | | shift by License Nurse. | |
| | | 11:15 A.M., a facility | | | |
| | | ng form was reviewed. | | | |
| | • | icated Resident #56 | | What measures will be put in | to |
| | had diagnoses | which included but | | place or what systemic chang | |
| | were not limite | d to: dementia with | | you will make to ensure that t | l l |
| | behaviors, anx | iety, and psychosis. A | | deficient practice does not re- | cur |
| | | he incident indicated, " | | | |
| | Only outside 5 | | | 1. Plan of care and C.N.A. | |
| | (temperature) | | | assignment sheets have been updated to reflect changes as | |
| | | Resident opened | | appropriate. | ' |
| | | and got out into locked | | 2.In-service for all staff by | |
| | _ | _ | | DNS/Social Service on April | 10 |
| | _ | been c (with) nurses | | on elopement policy and | |
| | | utside." Immediate | | procedures. | |
| | | Family and MD notified. | | 3.Motion sensor alarm plac | ed |
| | _ | ght back into building- | | on court yard door. 4.Alarm pad is utilized to er | ator. |
| | full body asses | | | court yard from facility. | ilei |
| | | asures taken: "Key pad | | 5.Device received to check | |
| | to door set to b | e locked at all times & | | motion detector bracelets for | |
| | 15 min (minute | e) checks started." | | functioning. | |
| | | | | 6.Placement and function o | l l |
| | On 3/16/12 at | 10:14 A.M., during | | wander guard is checked each | ch |
| | | irector of Nursing | | shift by License Nurse. | |
| | | d which door Resident | | | |
| | | ed and had exited the | | | |
| | | | | | |
| | liacility on 1/8/1 | 2 unsupervised. This | | | |

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Event ID: FCBV11

Facility ID: 000314

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | SURVEY | |
|--|--|---|-------------------|----------------------------------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | л ріш | LDING | 00 | COMPL | ETED |
| | | 155478 | A. BUII B. WIN | | | 03/26/ | 2012 |
| | | | D. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIER | ₹ | | | | | |
| TIMPED | S OF JASPER THE | | | | OWARD DR | | |
| HIVIDERS | 5 OF JASPER THE | | | JASPER | R, IN 47546 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID PROVIDER'S PLAN OF CORRECTION | | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΓE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | exit door was to | o the left of the door to | | | | | |
| | the secured unit (cottage) when coming from the 300 hall (where | | | | How the corrective action(s) w | ill | |
| | | | | | be monitored to ensure the | | |
| | Resident #56 r | • | | | deficient practice will not recur | , | |
| | | m was observed beside | | | i.e., what quality assurance program will be put into place | | |
| | • • | | | | program will be put litto place | | |
| | this door. The DON indicated at this time Resident #56 would have been | | | | To ensure compliance, tl | ne | |
| | | | | | DNS/Designee is responsible | | |
| | | when he had exited | | | the completion of the Missing | | |
| | the facility. The DON activated the | | | | Resident/Elopement QI tool | | |
| | keypad by the door and exited to the | | | | weekly times 4 weeks, bi-mon | thly | |
| | secured courtyard area. A large red | | | | times 2 months, and then | | |
| | button (above wheelchair level) was | | | | quarterly until continued compliance is maintained for 2 | | |
| | pressed on the | outside of this door (in | | | consecutive quarters. The resi | | |
| | · · | by the DON. The | | | of these audits will be reviewe | | |
| | | ole to re-enter the | | | by the CQI committee oversee | | |
| | | ssing the red button | | | by the ED. If threshold of 95% | | |
| | | • | | | not achieved an action plan wi | | |
| | _ | door knob of this exit | | | be developed to ensure | | |
| | | /12 at 10:25 A.M., the | | | compliance. | | |
| | | lemonstrated the door | | | | | |
| | | turned completely not | | | | | |
| | just half way or | the outside door | | | | | |
| | would not oper | n to enter the building. | | | | | |
| | - | | | | | | |
| | | | | | | | |
| | On 3/16/12 at ⁻ | 10:5., the Administrator | | | | | |
| | | d regarding Resident | | | | | |
| | | facility unattended on | | | | | |
| | | ministrator indicated | | | | | |
| | | | | | | | |
| | | ent exited the facility | | | | | |
| | | 50 P.M., the door the | | | | | |
| | resident used to exit would have been | | | | | | |
| | unlocked in day light hours when he | | | | | | |
| | had exited. She indicated after this | | | | | | |
| | incident the fac | cility had chosen to lock | | | | | |
| | | g day light hours also. | | | | | |
| | l ' | - · · · · | 1 | | | | 1 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2012 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION IDENTIFICATION NUMBER. | (X2) MULTIPLE CC | | (X3) DATE SURVEY |
|-----------|--|------------------|--|------------------|
| AND PLAN | OF CORRECTION IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED |
| | 155478 | B. WING | | 03/26/2012 |
| NAME OF F | PROVIDER OR SUPPLIER | | ADDRESS, CITY, STATE, ZIP CODE | |
| TIMPED | C OF IACRED THE | | OWARD DR | |
| TIMBER | S OF JASPER THE | JASPEI | R, IN 47546 | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIENCY MUST BE PERCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| | She indicated at the time of the | | | |
| | incident the resident had been in a | | | |
| | wheelchair and the temperature had | | | |
| | been 58 degrees. The Administrator | | | |
| | indicated a resident who had resided | | | |
| | in a resident room by this exit door | | | |
| | had alerted staff to the resident being | | | |
| | outside. She indicated at this time | | | |
| | that other residents and families using | | | |
| | this exit door to the courtyard area | | | |
| | had not complained of any difficulty | | | |
| | getting back inside the facility. During | | | |
| | interview at this time the Administrator | | | |
| | indicated Resident #56 had not left | | | |
| | the facility unattended before or after | | | |
| | the 1/8/12 incident. The | | | |
| | Administrator also indicated that | | | |
| | Resident #56's wander guard bracelet | | | |
| | would not have worked on the door | | | |
| | the resident had exited from on 1/8/12 | | | |
| | because the courtyard area was | | | |
| | enclosed. | | | |
| | | | | |
| | On 3/16/12 at 11:15 A.M., Resident # | | | |
| | 56's care plan was reviewed. His | | | |
| | care plan had been initiated on | | | |
| | 11/19/11 and addressed the problem | | | |
| | of " Resident is an elopement risk." | | | |
| | The goal target date had been | | | |
| | updated to 5/19/12. The long term | | | |
| | goal indicated, " Resident will not | | | |
| | leave facility unattended; resident | | | |
| | safety will be maintained." | | | |
| | Interventions of the care plan | | | |
| | (initiated 11/19/11) included: to | | | |
| | l . | | I. | l . |

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Event ID: FCBV11

Facility ID: 000314

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2 | | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE S | SURVEY |
|---|---|------------------------------|---------|------------|--|-------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A RIII | LDING | 00 | COMPLETED | |
| | | 155478 | B. WIN | | | 03/26/2012 | |
| | | | P. (VII | | ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| NAME OF P | PROVIDER OR SUPPLIEF | ₹ | | | OWARD DR | | |
| TIMBERS | S OF JASPER THE | | | | R, IN 47546 | | |
| (X4) ID | 4) ID SUMMARY STATEMENT OF DEFICIENCIES | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | identify the pat | tern of the resident's | | | | | |
| | wandering, elo | pement risk book at | | | | | |
| | the main office | and at each nurse's | | | | | |
| | station, and the | e resident to wear a | | | | | |
| | wander guard l | | | | | | |
| | _ | plan did not address | | | | | |
| | | f the wander guard | | | | | |
| | | ard to how often it | | | | | |
| | _ | ked or what staff was | | | | | |
| | | the monitoring of | | | | | |
| | compliance. | the monitoring of | | | | | |
| | Compliance. | | | | | | |
| | On 3/22/12 at 7 | 10:45 A.M., LPN #1 | | | | | |
| | (Resident #56's | • | | | | | |
| | l , | garding checking of | | | | | |
| | _ | | | | | | |
| | Resident #56's | _ | | | | | |
| | | dent #56's March 2012 | | | | | |
| | | ministration Record | | | | | |
| | ` ′ | riewed at this time. | | | | | |
| | This record had | | | | | | |
| | | of the checking of the | | | | | |
| | | bracelet placement and | | | | | |
| | function. LPN | | | | | | |
| | | was lacking of the | | | | | |
| | checking of Re | sident #56's wander | | | | | |
| | guard bracelet. | | | | | | |
| | | | | | | | |
| | On 3/22/12 at 9 | 9:20 A.M. a facility | | | | | |
| | policy entitled " | 'Missing | | | | | |
| | | dent Elopement" | | | | | |
| | revised on 3/10 |) was reviewed. This | | | | | |
| | policy included | but was not limited to: | | | | | |
| | "Security bra | celet and alarm system | | | | | |
| | 1 | d on a routine basis to | | | | | |
| | | e functioning" This | | | | | |
| | l | J | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FCBV11

Facility ID: 000314

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2012 FORM APPROVED OMB NO. 0938-0391

| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478 | | LDING | NSTRUCTION 00 | (X3) DATE COMPL 03/26/ | ETED |
|--------------------------|--|---|---------|---------------------|--|------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | p. w.i. | 2909 HC | ODDRESS, CITY, STATE, ZIP CODE DWARD DR R, IN 47546 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | | (X5) COMPLETION DATE |
| | policy also indicesidents will have on (if the facility monitoring systorder that will be often than daily. During interview A.M., the DON did not have a wander guard be take residents to see if the alarmindicated the face (universet to check residents bracelets. She ordered would tomorrow. She written physicial wander guard be and to docume resident treatmindicated one real ready had a pecheck her wander guard had been resident's mediated one of the check have a pecheck her wander guard had been resident's mediated one of the check have a pecheck her wander guard had been resident's mediated one of the check have a pecheck her wander guard had been resident's mediated the check have a pecheck her wander guard had been resident's mediated the check have a pecheck her wander guard had been resident's mediated the check have a pecheck her wander guard had been resident's mediated the check have a pecheck her wander guard had been resident's mediated the check have a pecheck her wander guard had been resident's mediated the check her wander guard had been resident's mediated the check her wander guard had been resident been pecheck her wander guard had been pech | cated, "Elopement risk ave a security bracelet y utilizes an electronic tem) per physician's te checked no less y" If you on 3/23/12 at 9:20 indicated the facility way to check resident bracelets except to to an alarmed door to a sounds. She utility has ordered a all door/trigger tester) int wander guard indicated the tester be at the facility the indicated she had an orders to check bracelets every shift int the checking on ment sheets. She esident on the 500 unit ohysician's order to der guard. She necking of her wander in documented on the cation administration | | | | | |
| | a motion sense | | | | | | |

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Event ID: FCBV11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2012 FORM APPROVED OMB NO. 0938-0391

| | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CO | | (X3) DATE SURVEY |
|-----------|--|--------------------------------|------------------|--|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED |
| | | 155478 | B. WING | | 03/26/2012 |
| NAME OF F | PROVIDER OR SUPPLIEI | 3 | STREET A | ADDRESS, CITY, STATE, ZIP CODE | |
| | | | | OWARD DR | |
| TIMBERS | S OF JASPER THE | | JASPE | R, IN 47546 | |
| (X4) ID | X4) ID SUMMARY STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PERCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE | TE |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | DATE |
| | installed on 4/4 | 1/12, on the outside of | | | |
| | the court yard | door. | | | |
| | | | | | |
| | 3.1-45(a)(2) | | | | |
| | | | | | |
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Event ID: FCBV11

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING | ONSTRUCTION 00 | (X3) DATE S COMPL | |
|--|---|---|---------------------------------|--|----------------------|------------|
| | | 155478 | B. WING | | 03/26/ | 2012 |
| | ROVIDER OR SUPPLIER | | STREET 2909 H | ADDRESS, CITY, STATE, ZIP CODE OWARD DR R, IN 47546 | | |
| (X4) ID | SUMMARY ST | FATEMENT OF DEFICIENCIES | ID | I | | (X5) |
| PREFIX | | CY MUST BE PERCEDED BY FULL | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | COMPLETION |
| TAG | • | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | DATE |
| F0441 | | , | | | | |
| F0441 SS=D | SPREAD, LINEN The facility must Infection Control provide a safe, s environment and development and and infection. (a) Infection Con The facility must Control Program (1) Investigates, infections in the facility must (2) Decides what isolation, should resident; and (3) Maintains a resident | establish and maintain an Program designed to anitary and comfortable to help prevent the d transmission of disease trol Program establish an Infection under which it - controls, and prevents | | | | |
| | (1) When the Infedetermines that a prevent the spreamust isolate the (2) The facility m communicable dilesions from directheir food, if directional disease. (3) The facility m hands after each which hand wash professional practice. | ust prohibit employees with a isease or infected skin ct contact with residents or ct contact will transmit the ust require staff to wash their direct resident contact for hing is indicated by accepted | | | | |
| | | rvation, record review, he facility failed to | F0441 | The facility's intent is to estab and maintain an Infection Con | | 04/10/2012 |

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Event ID: FCBV11

Facility ID: 000314

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | ONSTRUCTION | (X3) DATE SURVEY | | |
|--|-----------------------|------------------------------|---------|-------------|--|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | | 00 | | COMPLETED | |
| | | 155478 | A. BUII | | | 03/26/2012 | |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹ | | l | | | |
| TIMEDO | 0 OF 14 OPED THE | | | | OWARD DR | | |
| HIMBERS | TIMBERS OF JASPER THE | | | JASPEI | R, IN 47546 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE | |
| | ensure infectio | n control practices | | | Program designed to provide | | |
| | were observed | during medication | | | safe, sanitary and comfortable | | |
| | administration | by 1 of 5 nurses | | | environment and to help prevented the development and | ent | |
| | observed pass | ing medications to 6 of | | | transmission of disease and | | |
| | | Resident #79 Resident | | | infection. What corrective | | |
| | | #56 Resident #39 | | | action(s) will be accomplished | for | |
| | Resident #32 | | | | those residents found to have | I | |
| | Nesident #32 | Nesident #2 | | | been affected by the deficient | | |
| | | la. | | | practice | | |
| | Findings includ | ie: | | | 1. A review of the medical | | |
| | | | | | records of residents #79, #37, | | |
| | | m 4:00 P.M. to 4:40 | | | #56, #39, #32, #2 was comple 2.R.N. # 3 was counseled. | etea. | |
| | P.M., RN #3 w | as observed passing | | | 3.R.N.#3 was placed into | | |
| | medication. | | | | orientation for re-training and | | |
| | | | | | completion of validation skills | | |
| | She was obser | ved to prepare | | | check off list completed which | | |
| | | administration to | | | included hand washing. | | |
| | | She administered the | | | How will you identify other | | |
| | | uching the resident's | | | residents having the potential | | |
| | | ulder and articles in | | | be affected by the same defici | ent | |
| | | | | | practice and what corrective action will be taken | | |
| | | nout hand sanitizing | | | No other residents were | | |
| | | d medication for | | | identified. | | |
| | | n the process a pill | | | 2.License Nurses were | | |
| | | e floor. She picked the | | | in-serviced by DNS on 4/5/12 | | |
| | - | oor, discarded it and | | | regarding med pass | | |
| | continued with | the preparation without | | | administration which included | | |
| | | and administered it. | | | hand washing. | | |
| | | ated hands, she | | | What measures will be put in | I | |
| | | cation for Resident | | | place or what systemic chang you will make to ensure that the | | |
| | ' ' | ed water from a pitcher | | | deficient practice does not rec | I | |
| | | a plastic cup for the | | | 1. R.N. # 3 was placed in | | |
| | | ik from along with the | | | orientation for re-training and | | |
| | | _ | | | validation skill check off | | |
| | | the cup. Upon | | | completed for med pass which | າ [| |
| | | administration, she | | | included infection control | | |
| | contacted the f | | | | procedures. | for | |
| | contaminated (| glass as she placed her | | | 2.Validation skill check offs | IOI | |

| STATEMEN | IT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MU | LTIPLE CO | NSTRUCTION | (X3) DATE S | URVEY | |
|-----------|---------------------|--------------------------------|----------------|----------------|--|-------------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUIL | DINC | 00 | COMPLE | ETED | |
| | | 155478 | | | | 03/26/2 | 2012 | |
| | | | B. WINC | | | | | |
| NAME OF F | ROVIDER OR SUPPLIEI | R | | | ADDRESS, CITY, STATE, ZIP CODE | | | |
| | | | | 2909 HOWARD DR | | | | |
| TIMBERS | S OF JASPER THE | | | JASPE | R, IN 47546 | | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | • | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PERCEDED BY FULL | EDED BY FULL F | | (EACH CORRECTIVE ACTION SHOULD BE | | COMPLETION | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | IE | DATE | |
| | nalm down ove | er the glass while taking | | | med pass which includes hand | 1 | | |
| | • | nedication cart for | | | washing will be completed on | | | |
| | | | | | each licensed nurse on all thre | ee l | | |
| | | out hand washing, she | | | shifts completed by DNS and/o | or | | |
| | prepared the m | nedication for Resident | | | designee. | | | |
| | #56. She took | water along, | | | 3.License Nurses were | | | |
| | | ne medication and | | | in-serviced by DNS on 4/5/12 | | | |
| | | soiled water glass, in | | | regarding med pass | | | |
| | | ner recontaminating | | | administration which included | | | |
| | | • | | | hand washing. | | | |
| | | thout hand washing | | | How the corrective action(s) | will | | |
| | she completed | • | | | be monitored to ensure the | | | |
| | preparing and | administering | | | deficient practice will not recur | , | | |
| | medications to | Resident #39 and then | | | i.e., what quality assurance | | | |
| | Resident # 37, | without any hand | | | program will be put into place | . | | |
| | | ghout the entire | | | To ensure compliance, the DNS/Designee is responsible. | | | |
| | observation. | griode and original | | | the completion of the Medication | | | |
| | observation. | | | | Pass Procedure CQI tool week | | | |
| | | | | | times 4 weeks, bi-monthly time | | | |
| | | 4:00 P.M. the Director | | | months, and then quarterly un | | | |
| | of Nursing prov | vided facility policies | | | continued compliance is | - | | |
| | and procedure | s related to infection | | | maintained for 2 consecutive | | | |
| | control. During | g interview at that time | | | quarters. The results of these | | | |
| | ` | nand washing between | | | audits will be reviewed by the | CQI | | |
| | | its was a requirement | | | committee overseen by the ED | | | |
| | | • | | | threshold of 95% is not achiev | | | |
| | | ndated Standard | | | an action plan will be develope | ed | | |
| | _ | deline directed hand | | | to ensure compliance. | | | |
| | washing betwe | een resident care or | | | | | | |
| | handling items | which had been | | | | | | |
| | contaminated. | | | | | | | |
| | | | | | | | | |
| | 2 4 40/6\/4\ | | | | | | | |
| | 3.1-18(b)(1) | | | | | | | |
| | 3.1-18(I) | | | | | | | |
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FCBV11

Facility ID: 000314

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2012 FORM APPROVED OMB NO. 0938-0391

| | | 1 <i>EE1</i> 70 | A. BUILDING B. WING | 00 | COMPLETED 03/26/2012 | | | |
|--------------------------|---------------------|---|--|---|----------------------|--|--|--|
| NAME OF P | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR | | | | | |
| | OF JASPER THE | | | OWARD DR R, IN 47546 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | (X5) COMPLETION DATE | | | |
| | | | | | | | | |
| | | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FCBV11

Facility ID: 000314

If continuation sheet Page 20 of 24

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE C | (X3) DATE SURVEY | | |
|--|-----------------------------|------------------------------|------------------|---|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | COMPLETED | |
| | | 155478 | B. WING | | 03/26/2012 |
| | | | | ADDRESS, CITY, STATE, ZIP CODE | <u> </u> |
| NAME OF F | PROVIDER OR SUPPLIER | L . | | HOWARD DR | |
| TIMBERS | S OF JASPER THE | | | ER, IN 47546 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` ` | CY MUST BE PERCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| F0467 SS=E | 483.70(h)(2) ADEQUATE OU | TSIDE | | | |
| 33-E | | VINDOW/MECHANIC | | | |
| | | have adequate outside | | | |
| | | eans of windows, or | | | |
| | mechanical vent | ilation, or a combination of | | | |
| | the two. | | | | |
| | Based on obse | ervation and interview | F0467 | The facility's intent is to have | |
| | the facility faile | d to ensure the male | | adequate outside ventilation be means of windows, or mechan | , |
| | shower room p | rovided ventilation to | | ventilation, or a combination of | |
| | assist in reduci | ng objectionable odors | | the two. What corrective | '' |
| | for 1 of 1 male | shower rooms on the | | action(s) will be accomplished | l for |
| | 300 and 400 ur | nits. | | those residents found to have | |
| | | | | been affected by the deficient | |
| | Findings includ | e: | | practice 1. No residents were affected | |
| | | | | 2.Exhaust fan repaired | eu. |
| | On 3/12/12 at | 9:40 A.M., the building | | 03/22/12. | |
| | | r initial tour. Upon | | How will you identify other | |
| | | ilding from the main | | residents having the potential | |
| | _ | the following floor plan | | be affected by the same defic | ient |
| | | the nursing station for | | practice and what corrective action will be taken | |
| | | 0 halls was to the left | | No residents were affected. | ed. |
| | | ersection. The 300 | | 2.Laundry barrels will be | |
| | 1 | Il was located vertical | | disinfected once a week. | |
| | _ | or. The 400 nursing | | 3.Soiled briefs barrel will be | |
| | · · | cated to the right of the | | emptied once per shift and mo | ore |
| | | Directly to the right of | | often as needed. 4.Laundry barrels will be | |
| | 1 7 | was a resident TV | | emptied at least 2 times per | |
| | | | | laundry and more often as | |
| | | loorway to the room | | needed. | |
| | _ | unit hall. Directly | | 5.Exhaust fan repaired | |
| | | from the TV room, was | | 03/22/12. | into |
| | | r room and a women's | | What measures will be put place or what systemic chang | |
| | | again with the doors | | you will make to ensure that the | |
| | _ | e 400 unit hall. At this | | deficient practice does not rec | |
| | · · | ts were observed | | 1. Laundry barrels will be | |
| | sitting in their w | heelchairs in the TV | | disinfected once a week. | |

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Event ID: FCBV11

Facility ID: 000314

If continuation sheet Page 21 of 24

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155478 SUBJUDING SWING | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|---|-------------------------------------|-----------------------|--|--------------------------------|--------|------------|
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| they "wondered why the workers at don't notice the odor." weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive | | _ | | | | | 4 | |
| don't notice the odor." months, and then quarterly until continued compliance is maintained for 2 consecutive | | | _ | | | _ | | |
| continued compliance is maintained for 2 consecutive | | | • | | | months, and then quarterly un | til | |
| | | | 3 0001. | | | - | | |
| | | On 3/13/12 at : | 10 A M there again | | | | | |
| | | | _ | | | quarters. The results of these | COL | |
| was a pervasive stale urine odor noted in the 300 and 400 halls at the committee overseen by the ED. If | | • | | | | | | |
| threshold of 050/ is not solitored | | | | | | | | |
| an action plan will be developed | | | | | | | | |
| shower rooms. This pervasive foul to ensure compliance. | | | • | | | | | |
| odor remained to be detected at 11 | | odor remained | to be detected at 11 | | | r | | |
| A.M., 12 P.M., 1 P.M. and 2 P.M. At | | A.M., 12 P.M., | 1 P.M. and 2 P.M. At | | | | | |
| this time, 3 residents were observed | | | | | | | | |

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Event ID: FCBV11

Facility ID: 000314

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | SURVEY |
|--|----------------------|------------------------------|--------|------------|-------------------------------------|------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A RIII | LDING | 00 | COMPL | ETED |
| | | 155478 | B. WIN | | | 03/26/2012 | |
| | | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF E | PROVIDER OR SUPPLIEF | C | | 2909 H | OWARD DR | | |
| TIMBERS | S OF JASPER THE | | | JASPER | R, IN 47546 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PERCEDED BY FULL | | PREFIX | CROSS-REFERENCED TO THE APPROPRIATE | | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCE | | DATE |
| | | in their wheelchairs. | | | | | |
| | | e, 1 resident was | | | | | |
| | | g at the nursing station | | | | | |
| | | aiting a ride for an | | | | | |
| | appointment. | | | | | | |
| | | observed sitting at this | | | | | |
| | | aiting staff to push | | | | | |
| | them in their w | heelchairs to the dining | | | | | |
| | room. | | | | | | |
| | | | | | | | |
| | On 3/22/12 at | 11:30 A.M. CNA | | | | | |
| | (certified nursir | ng assistant) #10 was | | | | | |
| | interviewed. C | NA #10 indicated she | | | | | |
| | was working or | n the 300 and 400 | | | | | |
| | nursing units to | oday. She indicated | | | | | |
| | resident showe | ers are given in both the | | | | | |
| | units men's and | d women's shower | | | | | |
| | rooms. CNA # | 10 indicated usually | | | | | |
| | the women's sl | nower room is used as | | | | | |
| | the heater and | ventilation doesn't | | | | | |
| | work in the me | n's shower room. CNA | | | | | |
| | | that soiled resident | | | | | |
| | | s and sheets were | | | | | |
| | | arrels housed in one of | | | | | |
| | | stalls in the men's | | | | | |
| | shower room. | | | | | | |
| | 0.101101100111. | | | | | | |
| | On 3/22/12 at 3 | 3:05 P.M., the Mens | | | | | |
| | | on the 300/400 unit | | | | | |
| | | | | | | | |
| | | th the Maintenance | | | | | |
| | | ide the door, were | | | | | |
| | | ocated on the wall to | | | | | |
| | | of the switches | | | | | |
| | operated the li | ights in the room | | | | | |
| | | | | | | | |

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Event ID: FCBV11 Facility ID: 000314

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| | of Correction identification number: 155478 | A. BUILDING B. WING | 00 | COMPLETED 03/26/2012 | | | |
|--------------------------|---|---|--|----------------------|--|--|--|
| | PROVIDER OR SUPPLIER S OF JASPER THE | STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY) | ULD BE COMPLETION | | | |
| | when activated. The other switch, when activated, did nothing. At this time, the Maintenance Man removed a dust coated grate from the ceiling over the shower stall. He indicated this was the exhaust fan and that is currently wasn't working. He indicated he was unsure as to how long the fan wasn't working as he wasn't aware the fan wasn't working. At this time, 4 covered barrels were observed in one of the two shower stall areas. On 3/23/12 at 3:20 P.M., the ADON (Assistant Director of Nursing) was interviewed. She indicated there were 44 residents on the 300 and 400 unit halls that would use the men's and women's shower rooms. 3.1-19(f)(2) | | | | | | |

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